



# DEPARTMENT OF PUBLIC SAFETY

## DIVISION OF EMERGENCY SERVICES

Emergency Medical Services  
Emergency Management  
State Fire Marshal

Date: 03/13/2014 8:06 AM

This application is for the licensure period **July 1, 2014** through **June 30, 2016**.

Please complete the entire application and return it along with a **\$12.00 check/money order** (payable to: South Dakota Department of Public Safety) by June 15 to:

Office of Emergency Medical Services  
South Dakota Department of Public Safety  
118 West Capitol Avenue  
Pierre, South Dakota 57501-2000

It is important that your application is complete. An incomplete application will be returned; thereby causing a delay in relicensure. Those applications received after June 15 may result in a period of time that the service would not be licensed and third party reimbursement agencies may refuse reimbursement for services delivered during this time.

As changes occur in your service for the first and second contact person, please notify this office as soon as possible. This information will then be updated on our Web Page.

This will keep information flowing to the services in a more timely manner.

Thank you, in advance for your prompt attention. If you would like more information or clarification, please call the EMS Office at (605) 773-4031.

Ambulance License Number:

Service Name:

Service Address:

City:

State:

Zip:

**Ambulance Service Licensing Application**  
**South Dakota Emergency Medical Services**  
**July 1, 2014-June 30, 2016**

Transport Type In State Ground Transport

Licensing Initial License

Ambulance Service Number and Name:

Mailing Address

Street Address (for shipping via United Postal Service)

City

State

Zip + 4

Business Phone Number for Service

Emergency Phone Number to Access Service

E-mail Address

Person Completing Application

Phone Number

Fax Number

**Primary Contact Person for Service**

Work Phone

Home Phone

E-Mail Address

**Secondary Contact Person for Service**

Work Phone

Home Phone

E-Mail Address

**Medical Director's Name**

Address

City

State

Zip + 4

Work Phone

Home Phone

### Specific Ambulance Service Data

Service Number:

1. Ambulance Service is owned and operated by City

☐ Other

2. Is your Medical Director Paid?

3. Level of Service: Medical Transport

☐ Advanced Life Support

☐ Basic Life Support

4. What are your current charges for ambulance transports?

Loading Fee ALS

Per Loaded Mile Charge

Loading Fee BLS

Per Loaded Mile Charge

Other Charges

5. Do you charge separately for consumable supplies? Yes ☐ No ☐

6. Do you bill Medicare for service to eligible recipients? Yes ☐ No ☐

7. Do you bill Medicaid for service to eligible recipients? Yes ☐ No ☐

8. Do you charge patients the balance of a bill not paid by Medicare, insurance companies, or other 3rd party payers? Yes ☐ No ☐

9. The person responsible for the billing and claims process for your service is:

Name

Address

City  State  Zip + 4

Work Phone  Home Phone

Cell Phone

Service Number:



[illegible]

[illegible]